Procurement Review Workgroup

Final Report (Draft)

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INTRODUCTION

This is a draft of a final report of the Procurement Review Workgroup. Our purpose in sharing this in draft form is to solicit input on the issues raised by our work and the resulting preliminary recommendations. Many of our colleagues have expressed interest in contributing to our discussions. Some have feared that we would reach final conclusions and be wedded to a specific approach before others had the opportunity to share their ideas. This is not the case. We do have a vision for an integrated service system that is more than the sum of its parts and a proposed approach for achieving it. However, we recognize that our recommendations will be, and must be, strengthened through your questions and input.

This report begins by reviewing where we started – the vision, context and change initiatives at DSS that guided our work and to which our work is connected. We then present our recommendations for designing, managing, and purchasing a system-of-care. We have included a number of attachments in order to share the thinking and analysis that formed the foundation for our recommendations.

We anticipate and hope that many different partners will be interested in our work. We have done our best to speak to a variety of perspectives that readers will bring to this report. However, there is no doubt that we have not answered every question, filled in every gap, made explicit every detail. We look forward to receiving your comments and questions to help complete this report.

PURPOSE OF REVIEW

The Procurement Review began in September 2002 as one of five key initiatives identified by the Commissioner to improve the manner in which DSS utilizes its resources. In requesting this review of DSS' purchase-of-service budget (approximately $320M annually), Commissioner Spence's goal is to ensure that services are purchased in a manner that best supports children and their families. The purchase-of-service system has not been analyzed comprehensively as a system for several years and is in danger of being merely a collection of programs rather than a cohesive system. We are excited to finally have a forum for addressing the fundamental changes many of us (and you) believe the system needs and is ready to make. Our collective and individual experiences with Commonworks, Family Based Services, Community Connections, lead agencies, the Autho system, subcontracting, direct contracting, various rate structures, cross-agency issues, etc. tell us that past and current innovations provide lessons and a foundation on which to build a better system.

There are two larger contexts into which our work fits. The first context is that created by a series of change initiatives in development at DSS. There are initiatives in five key areas designed to improve case practice and management systems (one area being this review of its procurement system). These initiatives are deeply connected to each other, their success interdependent. They are in various stages of development, each one

informing the other as they move forward. The individual initiatives listed below are described in more detail in Attachment A.

- Create a community of practice by
  - implementing a Continuous Quality Improvement (CQI) program,
  - establishing a Professional Development Institute, and
  - designing and testing approaches to team-based case practice.
- Create a community-based continuum of care.
- Develop more effective approaches to Children in Need of Services (CHINS), including Family Group Conferencing.
- Strengthen DSS' capacity to address three key risk factors for children: family violence, substance abuse, and mental illness.

The second, larger context into which our work must fit is that created by the reorganization of Executive Office of Health & Human Services. Most of our deliberations were conducted prior to the unveiling of the proposed "cluster" organizational design. However, we did anticipate some reorganization that would integrate some (if not all) child-serving agencies. We believe that the reorg proposal and associated discussions have the potential to enhance the success of agency procurements. The reorg suggests the potential for developing a clear vision and a single set of shared outcomes that unify EOHHS' component parts. This is particularly true, and very much needed, for those children who receive services from multiple agencies. Currently, purchasing agencies and their contracted providers are often forced to solve problems through procurement that are essentially attempts to work around a fragmented human services system. Whatever happens with the reorg, the Workgroup hopes to see the end to the situation in which providers are forced to integrate separately procured contracts and their associated administrative requirements in order to serve one child. Doing so requires that planning work occur at the highest possible levels in order to properly support effective collaboration in procurement. We believe that our recommendations both facilitate and would be enhanced by this approach to planning and procurement.

Being mindful of these larger initiatives and dynamics is important because DSS is more than a purchasing agency; it has a full range of change initiatives, resources, and management tools available to accomplish its goals. In our discussions about the best use of procurement tools (old and new), we have noted that these tools can be blunt instruments when applied to some challenges. Fundamentally, procurement is a set of tools that supports and advances the agency's work and strategic direction. Our work has been to recommend approaches for improving and strengthening the procurement system. We believe that the purchase-of-service system offers many strengths and opportunities to DSS if it is a component of a comprehensive strategy.

PAST INNOVATION AND FUTURE OPPORTUNITIES IN THE POS SYSTEM

Over the past several years, there have been two important waves of reform in the purchase and delivery of services in the child welfare field. Key innovations in DSS' purchase-of-service system reflect those occurring nationally. The major program areas from which we have drawn important lessons in our review are Commonworks, Family Based Services, and Community Connections. These programs have design and operational features that form a foundation on which to build and to continue to improve DSS' purchase-of-service system. One of the most interesting and important challenges we face is finding a way to join the two reforms described below.

One wave of reform is that of public child welfare agencies establishing community partnerships to strengthen and empower communities to care for children involved in the child protection system. This work comes from the acknowledgement by public child welfare agencies that they cannot act in isolation to care for and protect children. For example, the guiding principles of the Casey Family-to-Family Program are that children do best in strong families, families can become strong when they have the support of their communities, and child welfare agencies can do their job better when they partner with communities in support of families. Just as family work honors and supports the executive functioning of families, community partnerships honor the executive functioning of the community, inviting them to make decisions about their children and take responsibility for their safety and well-being. This wave of reform applies community organizing and public health principles and techniques to child welfare.

The other wave of reform is the adaptation of managed care principles and techniques to child welfare. This occurred in Massachusetts (in Commonworks) and in many states and counties across the country over the past several years. Many 'managed care' initiatives employ lead agencies to manage a comprehensive care package for which the purchasing agency pays a case rate. These programs are typically designed to serve the portion of children in care who are generally referred to as the 'high end' cases. While these children constitute a small portion of cases, they utilize a large portion of resources – not just budget resources, but also staff time, attention, and energy at child welfare agencies struggling to provide quality care in a fractured system. Because these children need intensive behavior management, many initiatives blend funding and expertise from their mental health and/or Medicaid agencies.

As we reviewed DSS' system, we concluded that the programs designed according to the principles of these two reform movements should be better integrated through a new system design. Commonworks, Family Based Services, and Community Connections are separately procured, funded, and managed programs. Because they are separate programs, each one has been able to develop a special expertise to contribute to the new system. The new system will allow the transfer of knowledge across these program areas.

The Commonworks Program has expertise in providing effective behavior management developed in residential settings. Within Commonworks, MBHP has funded an

Enhanced Residential Care (ERC) program that blends Medicaid funds with DSS funds to care for youth with very high-end needs. Services in community and family settings could be greatly strengthened by moving this expertise outside the walls of institutional settings.

The Family Based Services Program is managed by lead agencies contracted directly with Area Offices. Leads' service coordinators are co-located in Area Offices. This uniquely positions them to focus on managing the service network while being attuned to daily needs and stresses of an Area Office. They are able to track Area trends and respond quickly to craft appropriate solutions (e.g., practices, programs, etc.).

Community Connections, while a smaller program, has built expertise in partnering with communities, particularly residents and non-traditional supports. Families are able to identify the supports that they would find helpful to them and then work together to develop them.

In designing a system that responds to the "care & protection" role of DSS as well as to the increasing role it plays as gatekeeper to and provider of behavioral health services, it is tempting to see these as two separate roles requiring separate procurement responses. One could well imagine local systems-of-care as catalysts for powerful community partnerships that ensure the safety and well-being of children and regional entities (whatever their name) coordinating the care of 'high end' youth across state agencies. However, this is too simple. We believe it is important not to have separate systems for 'high-end' and 'low-end'. Access across the full array of the continuum of services is important for all children and families. All children and their families need the support of their communities. Building local service networks and helping families use their natural supports increases their options as they nurture their children, whether in-home or when accessing out-of-home placement or some combination. Access to behavioral health services must not come at the cost of moving a child away from their family and community. Designing such an integrated system requires bringing into balance the medical/ behavioral health model with the public health model.

<u>Transition from Here to There</u>

One of the challenges in designing a new system is that the starting point of the new system looks more like the 'old' system than the desired one and, therefore, will 'inherit' the current allocation of resources across the service continuum. We want to design a system that works for all the children involved with DSS. Yet, we are mindful that most of the resources in the current system are spent providing care for a small percentage of children at the 'high end' and that the focus on these children overwhelms the system's ability to respond appropriately to all children needing services. DSS' current purchasing approach has invested heavily in the care provided in residential settings, but not sufficiently in community-based and in-home services. In fact, the current allocation of resources and the purchasing methods has built a critical mass at the high end / residential placement end of the continuum that exerts an enormous gravitational pull away from community-based care. We have noted in our *Principles* the importance of providing services earlier than the system currently does, doing so in a manner that builds

connections to community supports that can be sustained after DSS' departure, and not forcing children to 'fail up and in' to services. We believe that it is important to intervene when children are young, before they are traumatized by delays in receiving appropriate supports. All of this will require a transition period during which savings from improvements in service delivery at the 'high end' can be reinvested in improving the front end.

The transition from today's service system to the one we envision will be a multi-year transition. This will require DSS to set out clear timeframes for meeting specific benchmarks, to manage its vendors diligently, and to attend to related internal operations. Our proposed vision for local systems-of-care is revolutionary, but will take place in an evolutionary manner. Benchmarks should be established to monitor / measure the development of the system in key areas. Doing so will ensure that DSS minimizes its risk as purchaser and steward of public funds as well as protects the quality of services delivered to children and families.

RECOMMENDATIONS

The scope of the Review was defined broadly to include how services are designed and managed as well as the business practices that support quality services. We began by examining how services are currently accessed and used throughout the life of a case. From this we established a shared vision about how our principles shape the look and feel of services and the service system. The first set of recommendations addresses organizing services in a system-of-care. Knowing that describing a good system-of-care by defining its principles and indicators would serve as the foundation for the rest of our discussions, we spent substantial time on this and consider it the most complete component of our recommendations.

We then distinguished between buying services organized as local systems-of-care from buying the necessary business capacity to manage the systems-of-care.[1] Untangling the two was not easy, in large part because we see a role for service providers in using their expertise in managing services (not just providing them). Specifically, we see a role for Area-based Lead Agencies in partnering with Area Offices and for Regional Resource Centers to partner with Regional Offices as well as form a collaboration with Area Leads to enhance and support their work. This is the component of our recommendations on which we most want challenge, modification, and insightful guidance. We believe that the framework we have developed has the potential to integrate fully a complex system. However, it raises more questions than it answers, many of which are operational and beyond the scope of our Review. We hope that readers will help identify additional questions as well as offer possible solutions.

The business practice recommendations cover the more traditional procurement subject matter. They are intended to stand regardless of the specific purchasing approach used. That is, some of the recommendations address the lead agency model; others address purchasing services in any manner.

For those who like to skip to the end result, Attachment E presents a vision of a community-based system-of-care written by one of our Workgroup members as she reflected back on our six months. It is helpful to imagine how individual recommendations could come together in a day at an Area Office. Attachment F presents criteria for evaluating our recommendations that we established at the beginning of our Review. Readers might find it useful in providing feedback on this Report.

Recommendations for Designing Local Systems of Care

We began knowing that DSS was interested in developing local systems of integrated services. The system-of-care subcommittee was charged with taking the lead in establishing principles as well as the indicators of those principles in operation. We

[1] This is not intended to dictate a specific approach to crafting and issuing RFRs. Distinguishing between organizing services as a system-of-care and managing services is important for analytic and design purposes. It will be DSS' operational team's responsibility to develop the appropriate RFRs.

examined the flow of a case from intake to discharge in order to identify what worked well and what we wanted to improve, particularly as it applies to purchased services. The full *Principles & Indicators* document is included as Attachment B.

Guiding Principles

Systems-of-care must:
- ✓ Be family-centered
- ✓ Build community capacity to serve families
- ✓ Emphasize prevention and early intervention
- ✓ Allow smooth transitions between programs
- ✓ Be effectively integrated and coordinated across systems
- ✓ Seek to evolve and change
- ✓ Provide rapid, timely access to services

Services must:
- ✓ Build on a family's strengths, in a manner respectful of the family system
- ✓ Be individualized to meet the needs of families
- ✓ Promote mutual accountability among all partners
- ✓ Be respectful of identity and affinity differences
- ✓ Be evaluated for outcomes continually

Defining a Local System of Care

We view a local system-of-care as containing a comprehensive array of services that meet the needs of low to moderate to high risk children and families. Families would be able to access single services, multiple services, or a comprehensive service package. Our working assumption has been that the current services to be rolled into (replaced by) this new model include residential (both Autho and Commonworks), family based services, and some components of contracted foster care. Each local system-of-care would create a network of relationships among community services and residential services (with residential services 'backing up' community services by providing diagnostic assessments, crisis intervention, respite, etc). However, there will always be the need for long-term residential care to support some children. These services are not limited to a local system since they are currently organized as a statewide system.

Now that DSS' appropriation account structure is less categorical, there is an opportunity to break down the barriers between service categories. Blending these service dollars creates the opportunity to invest any savings that accrue at the high end into building more options to support children in families and in communities and to prevent the need to access out of home / out of community care.

What Will Services Look Like?

Our vision of a system-of-care is one that supports the ability to unbundle services that are currently / typically bundled as well as to bundle services that are currently / typically unbundled in new, creative ways. We referred previously to wanting to access the behavioral management expertise held by residential providers for children not in placement. One example is paying for a staff member from a residential program to support a youth who has left the program to return home. This would support the family during a crucial transition. Allowing this type of 'unbundling' of a residential program might not only ease a transition, but also enable it to happen sooner. Another example is purchasing 24/7 support for the Department's foster homes from providers of therapeutic foster care. The Department currently purchases from these providers both a foster home and 24/7 support to their own homes as a 'bundled' service. Unbundling the support service and delivering it to Departmental homes (including kinship homes) could expand the number of foster homes better able to care for and support children in foster care.

The Role of Families

As noted in the Purpose section of this document, one of the key interests in the Review is to ensure that services were purchased in a manner that best supports children and their families. This can be accomplished only by involving families at all levels of the procurement process, and in particular, by requiring family involvement in RFR development and review as well as in program evaluation efforts. It is, for the most part, a given that state agency personnel and providers will be represented as stakeholders in these processes. But while family participation in service planning is a given in a family-centered system of care, the role of families in decision making around oversight and governance of purchased services is not a "natural fit" to state agency personnel and provider organizations used to making decisions about such things for families. Nor is it necessarily a "natural fit" for families unused to being involved in this level of the decision-making process. The transition to this level of involvement will require intense and ongoing education for families and professionals alike.

At a minimum, in the proposed model, families should be active members of any advisory groups established at the Area Lead level and/or the Regional Resource Center level. At the Area level, this would ensure the purchase/provision of community based services that truly reflect the needs of families. At the Regional level, families would participate in some of the management support functions, specifically around the development and review of program proposals and evaluation efforts. Additionally, a statewide role for family participation should be incorporated into the model. Organizationally, the goal is to get to the point where it is as natural to involve families in each aspect of the system-wide decision-making process as it is to include other, more traditionally included stakeholders

Recommendations for Managing Local Systems-of-Care

As noted above, this is the area in which our deliberations came to a tenuous conclusion. Perhaps because we were not assembled to provide operational analysis, it was harder to

reach consensus about the management / business capacity needed to manage integrated systems-of-care. The Workgroup believes using a private partner with expertise in the service system will allow DSS to focus on its areas of expertise and obligation (e.g., protective work, court work, etc.). Contracting with providers for their expertise builds on current strengths in the service system (in which DSS has made some investment). See Attachment C for our analysis of the benefits and challenges to using lead agency models. There is general agreement about the value of Area-based Lead Agencies. We also discussed the best way to support Area Leads and concluded that there is likely a need for a Regionally-based Resource Center. However, defining the roles and relationships among between these two entities and with DSS Areas and Regions has been the greatest challenge in our deliberations. Attachment D presents a diagram of our recommended model.

Guiding Principles

- ✓ Accountability, responsibility, and authority should be co-located, at the right organizational level.
- ✓ DSS Area Offices should be strengthened through and by their partnerships with providers and families.
- ✓ Public-private partnership builds on the best of what each partner can offer, combined in a win-win design, not diminished by an "either/or, all or nothing" view of public v. private.
- ✓ Management and administrative capacity should be built as close to the Area level as possible, but aggregate up as far as necessary to be as efficient as possible.
- ✓ The primary beneficiaries of joint planning and procurement with sister agencies must be families and children (not the agencies themselves).

Area-based Lead Agencies

There is consensus in the Workgroup for recommending the use of Area-based Lead Agencies as the key to building local systems-of-care as well as the role that this Lead would play. The Area Lead is the single point of entry for the local system-of-care. Workgroup members strongly believe that families and social workers should not have to navigate a complex or bifurcated system. The Lead's specific responsibilities are to:

- Develop and manage access to local systems-of-care
- Join DSS case planning teams in order to provide expertise on service availability and to develop individualized services as necessary
- Facilitate service access
- Monitor progress towards service goals
- Review utilization of services
- Recommend changes in service intensity, duration, and termination
- Manage relationships with network providers
- Identify and partner with non-traditional systems of care (community groups, parent groups, faith community), schools, municipal services, etc. in collaboration with Community Connections and DSS Area Boards

- Develop local community-based programs, based on the Area Office's CQI/needs assessment results

The term "area-based" does not mean that there will be 29 different providers serving as Leads to the 29 Area Offices. There might be Area Offices for whom it would make sense to join together to share a Lead Agency. For example, the Department used 29 as 'starting math' for its Family Based Services system, with an end result of 18 lead agency contracts held by 11 providers. Some of these are large providers doing business statewide; others are small providers doing business in a limited number of Areas. This "Multi-Area Lead" approach, or any other, would have to adhere to the *Principles* and embody the 'best of' area-based and regional-based entities.

When we use the term community-based we are referencing the importance of integrating natural supports and community services with purchased services to create local systems-of-care. It is not intended to suggest that only a 'homegrown' community-based provider can function as a lead agency. Community-based means that as the Lead coordinates and develops services, it does so in a manner that recognizes and respects community leadership and the strengths of community systems and that it knows how to graft purchased services onto community services without duplicating or weakening the community. The Lead and its network providers would help each other develop community competence. In addition, there is another level to the definition of community-based that relates to building community capacity as described previously in the discussion of community partnerships. While the Lead would have a role to play in this, it must do so in conjunction with the Community Connections coalitions, where available, and the Area Boards.

Regional Resource Centers

The purpose and need for a Regionally-based Resource Center has been harder to define and reach consensus on. We see the Resource Center has having two sets of responsibilities. One is to enhance / extend the capacity of the Regional Offices to ensure quality in their Region's purchased service system by providing management expertise and capacity. The other is to form a collaboration with the Area Leads in that Region to enhance their work and coordinate and extend their reach into statewide systems. This could include consolidating purchasing power for services of high intensity and/or low frequency. The RRC is essentially invisible to the Area Office social workers, who access services through the Area Lead, even those services developed and coordinated at a regional level. A Resource Center representative could join the service planning team for cases with intensive service needs. They would do so as a resource to the team, perhaps even providing an intensive level of service management (while case management remains at the Area Office). Its specific responsibilities are to:

- Develop programs to serve special populations / needs which a single Area does not serve enough to purchase its own program (e.g., firesetters)
- Provide leadership and consultation to residential providers on delivering their behavior management services in the community, in partnership with community-based agencies and foster families

- Coordinate the CQI process as it relates to purchased services, in conjunction with Regional Office
- Monitor system functioning in conjunction with Regional Office and Area Leads
- Ensure consistent application of DSS service standards, case practices, and management protocols
- Provide to Area Leads consultation and support in managing high end cases, particularly those that involve multiple state agencies
- Integrate services and funding from other state purchasers and MBHP

Governing Board

The proposed model also includes a Governing Board on which would sit the Regional and Area Directors, the Executive Directors of the Area Leads and Regional Resource Center, family representatives, and a representative from Central Office. The Board would be the governing vehicle for collaboration on policy, programmatic, and managerial issues.

Investment / Affordability

One of the Workgroup's concerns is whether the Department can afford to invest in a network management structure of 29 Area Leads and 6 Regional Resource Centers. We do note, however, that the Department currently purchases a similar structure separately through Family Based Services and Commonworks. Continuing do so but through a more integrated structure would seem to be a good investment. Holding Lead Agencies and Resource Centers accountable for client, process, and system outcomes ensures that this funding is not merely administrative in nature, but rather focused on managing services for children and families. Many of us have lamented the lack of financial support for all the work required to manage services effectively. Those with experience in Commonworks believe that the investment in care coordinators is an important factor in that program's success. Some Workgroup members have suggested that the investment in our proposed model is easier to justify if the 29 Area Leads and/or the 6 Regional Resources Centers integrate services beyond those purchased by DSS.

Regional Markets

One of the potential benefits of Regional Resource Centers is the creation and management of regional markets. High-end services (e.g., residential, psych hospitals) are currently organized as statewide markets. These services would pose a challenge to Area-based Lead Agencies because children are often placed in programs well beyond the geographical bounds of the Area Office serving them and in programs in which a single Area might have only a small number of children. Concerns were raised about how 29 Area Leads could have purchasing power in a system of approximately 200 residential programs (run by approximately 100 providers) and how they could monitor quality, address compliance issues, etc.

Consolidating purchasing power at the Regional Resource Centers would likely improve the access, quality, and cost value of these services. Establishing 'preferred provider' / 'core provider' subcontracts (that mimic maximum obligation contracts) within a Region

could make business flow more predictable for providers and availability more reliable for DSS and its Area Leads. Some Workgroup members recalled favorably the early Commonworks model, which was built with only maximum obligation contracts. Although it had the drawback of limiting participation and competition (a drawback to avoid recreating in the new system), it created a regional system in which providers worked together collaboratively. We also reflected on the current statewide Autho system, which diffuses the buyer-seller relationship. A purchasing approach that tightens the relationship and makes it more reliable also establishes a basis for asking more of providers without putting them at more risk than they can reasonably bear. As we move towards the system-of-care vision, we would want the option of buying services from residential providers much differently, including as backing up and supporting community based care. This change might be easier to effect in a system that supports regional markets.

Who Does What Work

As we bring all these partners together, we must clearly define each one's role and scope of responsibility. The Workgroup sees the Leads enhancing the work of the Department by bringing to bear its expertise in service design and delivery. It is our assumption that DSS will not and should not privatize case management. The Department has invested in the recruitment and retention of a high quality social work staff. Given that, there are significant questions regarding the relative responsibilities of DSS social workers and Lead Agency service coordinators. In order for any use of a lead agency model to work, the lead must be given clear authority commensurate with the degree of accountability to which they will be held. DSS members noted that legal (and public) liability is held solely by DSS. Provider members noted that involving the community in real partnership, in which it holds some accountability, requires that DSS not attempt to retain all authority for service-related decisions for itself. We believe that team decision-making is an important response to this challenge because it eliminates a tug-of-war between two individuals. Equally important is involving families in team meetings. 'Authority' issues would be mitigated as all parties would work together to develop a plan that is amenable to the family. Mechanisms to create consensus should be established, as should mechanisms to resolve situations in which consensus cannot be reached.

Performance Standards

We believe that it is important to align the focus and efforts of the public and private partners by holding them accountable for the same outcomes. Specifically Area Offices and Area Leads should be held accountable for the same outcomes as should Regional Offices and Regional Resource Centers. The standards /outcomes for network providers should be consistent with those for the Leads. The actual measures for the outcomes might be different since each entity will focus on events occurring in different time horizons. However, while the public and private partners should be held accountable for the same outcomes, the incentives used to encourage and reward performance might need to be different. The Workgroup did not take as its charge selecting outcomes for purchased services beyond noting that there are three types of outcomes: client, process, and system (see Attachment G).

Recommendations for Purchasing Local Systems-of-Care

We recognize that the on-going budget debate about service funding levels is important and not unrelated to our work. However, we are conducting a procurement review, not a budget review. Therefore, while others conduct the "more or less" discussions about the level of funding, we saw our charge as discussing strategies to improve the quality of the POS dollar. The principle of best value guided our deliberations and the recommendations that follow. Some recommendations specifically address the use of lead agencies; others are intended to govern any service procurement. Attachment H describes our view of the market in which DSS and its provider agencies conduct business.

Guiding Principles

- ✓ Best value, defined as spending the right amount of money at the right time for the right service to achieve the right outcome, is the foundation for all business practice principles and recommendations.
- ✓ Rates of payment must be adequate to create and maintain service capacity and quality. They should reflect a rational, clear analysis leading to a determination that the price represents true value and can reasonably lead to the successful achievement of identified outcomes.
- ✓ Incentives should be included to support the long-term outcomes desired for the system as a whole.
- ✓ The determination of the ongoing success (and therefore funding) of programs and services must be based on the outcomes they produce, rather than the activity they perform.
- ✓ For any financing strategy to be successful, it must be guided by regular and efficient review of clear, accurate, and actionable data that describes the operation of the system overall (including caseload, expenditure, and outcomes data) and the achievement of desired outcomes.
- ✓ The procurement process should be fair and equitable for DSS and all contracting and subcontracting providers.
- ✓ DSS' commitment to the health, vitality, and diversity of local systems-of-care and service networks requires it to establish parameters within which any lead agency identifies, selects, contracts with, and rewards service providers. These parameters should promote processes that are flexible, family-centered, and support integration of services.
- ✓ In order for networks to be vibrant and healthy, procurement processes must support the inclusion of a wide and diverse array of provider organizations (e.g., different types, sizes, expertise, and non-traditional organizations).

Institute improvements in any lead agency procurements that build positively on our experience with these models over the last few years.

- Notification

The process of notifying the provider / service community regarding the opportunity to participate in DSS' systems-of-care and to work with children / families is critical. Whether DSS is buying services directly or purchasing through a Lead Agency, notification should be as broad as possible. When DSS chooses to use a Lead Agency to build a service network, it is important to evaluate their capacity to do so. The RFR for procuring Lead Agencies should be developed with the involvement of a variety of stakeholders, including families, and require bidders to propose the process that they will undertake to ensure broad representation in their network according to principles articulated by DSS. Reaching out to past participants in the DSS service system and to non-traditional agencies, involving families in identifying services / agencies, and the bidder's approach for keeping their network 'alive' are important evaluation criteria.

- Contracts

Even when DSS uses Lead Agencies to purchase services, it must maintain a role in establishing subcontracts. However, DSS should not attempt to 'have it both ways': to foster creativity and flexibility by contracting with a Lead, but pull back system management when it chooses. Leads should be allowed to lead, in accordance with a manageable, clear set of parameters. DSS should establish some parameters and guidelines for the purpose of ensuring fairness and consistency; create standard procedures and forms in order to build administrative efficiency; and provide technical assistance as needed. The intent is to strike a balance in the partnership between DSS and its Leads that allows both to bring its expertise and strengths to bear on the management of purchased services.

- Subcontracts

Both of the current lead agency models (Commonworks and Family Based Services) use unit rate, fee-for-service purchasing as the only method at the subcontract level. We believe that DSS should specify a mix of contracting methodologies based on the outcomes desired. We need to arrive at a system that is flexible enough to meet family needs and that ensures that providers can maintain the services needed. Of necessity, we recommend using a mixture of maximum obligation contracts and as-needed (non maximum obligation, a.k.a. fee-for-service) purchasing methodologies as well as new pricing strategies.

- Protection of Small and Community-based Agencies

The subcommittee recognizes that dependence on a lead agency model and use of such financing devices as case rates favors large agencies that have sufficient cash flow and administrative expertise to fulfill the roles demanded. However, families often need the particular services offered by much smaller agencies that serve a specific neighborhood, ethnic or linguistic group, or rural area. The procurement process must include requirements that these agencies have a fair opportunity to participate in the delivery of care. In order to ensure that all leads actively recruit and mentor community-based

agencies, we recommend that the RFR include this outcome as an important requirement, and that annual performance measures for the lead include this component for qualification for any reward payments.

- Network Membership

The business practice subcommittee believes that the vitality of the networks depends on a limit on self-referral by Lead Agencies and a commitment to expanding the number of providers caring for children / families. Networks must include small providers, non-traditional / unincorporated providers, minority business enterprises, etc. To support and encourage a true diversity of service providers / participants, DSS should require different levels of contract documentation, based on the level of business a provider can be anticipated to receive.

- Communication

The Lead Agency model works best when there is routine communication with and among the subcontracted agencies in their network. It is important that the contract for a lead agency specify regular meetings with program directors to discuss the needs of specific families and with subcontractor executive directors to ensure that there is adequate ongoing communication regarding larger service system and general administrative matters.

Institute a pricing policy that sets floors under critical costs, such as direct care salaries, and that demands transparency in pricing and includes regular adjustments of multi-year contracts for inflation and new mandates.

Pricing is at the heart of the purchase-of-service system. Because approximately 70% of a rate covers staff costs, pricing directly affects the quality of care for children / families. Providers came to this Review at a time when their financial health is under pressure from a range of outside influences, including dramatic increases in healthcare and liability insurance costs. With no option but to pay these bills, providers are forced to reduce spending on staff, including paying lower salaries, not filling vacancies, etc. To respond to these pressures, providers have pursued a number of avenues to advocate for rate adjustments and relief from current policies and practices that cap rates. At the same time, the Commonwealth is facing enormous fiscal pressure and is confronting a broad range of spending reductions, drastically reducing / eliminating the resources available to offer rate relief.

- In order to eliminate vacancies, reduce turnover, and maintain consistent staff relationships with clients, there should be an appropriate floor for direct care salaries. Two years ago, providers advocated for a floor set at $25,000; it would be somewhat higher today. Other salaries should be scaled from this base. Clinical positions must be priced at market rates. Market rates should also be used for key items such as health insurance, other insurances, travel, and utilities. Additionally, assuming the participation of family members in a newly designed system of care, compensation levels must be established for those positions. The purpose of establishing market rates is to provide a guideline for DSS and bidders to follow in pricing services. The

use/application of these market rates can vary; variances (up or down) should be justified by the party proposing them.

- We realize that it would be inefficient to require the Department to come up with a detailed component price list each year unless such a list becomes available from OSD. However, if it is not available, we suggest that new guidelines for a few key items such as suggested above be published each year. These guidelines will likely be ranges to accommodate the variances in markets across the state.

- The party establishing a maximum obligation and/or rate as part of a procurement process must explain the methodology used to arrive at both as well as demonstrate that the rate supports the contractual scope of service, including achieving the identified outcomes; meets all required standards; and can be achieved in the current marketplace. This is true of DSS, lead agencies, subcontractors, and any agency participating in a joint procurement.

- The above principles are intended to specify clarity and shared information. They should not prohibit a respondent from offering a new way of pricing the service that meets both the service delivery principles as well as basic fairness to staff. The concept of "best value" should provide opportunities for competition and creativity.

- Once a price is determined and the contract awarded, then that price should be adjusted each fiscal year for the OSD published rate of inflation, as is already the case for Chapter 766 special education schools. It is understood that this adjustment needs to take place within the Department's budget allocation. Consequently, the adjustment might require some negotiation such as the purchase of fewer units, a change in the services delivered, etc.

- New mandates must be assessed for their cost impact. Contracts must be adjusted either by changing the scope to offset the cost of the new mandate or rates must be upwardly adjusted to pay for any new mandate added during the prior year.

- A comprehensive rate is one that covers a broad range of service components that the provider would select based on their work with the child / family. DSS could benefit by increased use of such rates (a.k.a. case rates or family rates) to purchase services not only from Lead Agencies but also from subcontracted providers able to deliver a variety of services.

- A cost reimbursement payment method is valuable for program start-up when developing capacity and ramping up referrals. However, it should be used for a limited period of time (e.g., one year) after which a more service-based rate should be established.

- The problems identified with an open-order or as-needed payment system are not as much a problem with the rate type as with the lack of a maximum obligation contract that establishes a predictable level of business. DSS should develop a subcontracting tool for the Leads to use with providers that identifies the level of service referrals

they could reasonably expect during a fiscal year. Without some predictability, fee-for-service payment forces providers into bigger models in order to spread their costs. Additionally, the lack of a more formal commitment of funding on an on-going basis might negatively affect providers' ability to get financing, to address capital borrowing needs, or to maintain lines of credit.

- There might be some services (e.g. emergency response) that require a predictable level of funding and should not be purchased without a guaranteed level of business.

- There might be some services for which DSS should pay a "price premium", e.g. services from smaller agencies closer to community, services with specific linguistic / cultural capacity.

- Performance incentives should be shared with providers, not limited to the Lead Agency. Incentives could include bonus payments and risk sharing.

- The state should pay the full cost of the services it needs to procure to meet the Commonwealth's obligations. It should not rely on providers' charitable contributions to offset costs. A major confusion in the POS system has been the unspoken expectation that providers will use charitable donations as an offset to their contracts. Many non-residential/education programs have not received a cost-of-living adjustment on their total program costs or any increase in fifteen years. The Legislature has, in some years, appropriated salary reserve funds for certain salaries, but not in consideration of the cost-of-living index. As a result, providers would not be able to continue services if they did not use community donations to subsidize services. However, the Department very much wishes to encourage families and children to use the services available from their communities. Much of what a family needs is available from schools, faith communities, clinics, and community agencies. One of the major qualifications of each Lead is to know its local service system and to be able to help families access these services. Thus the Department will procure from the Lead coordination services that will help make services from a variety of community agencies available to the Department's clients.

<u>Streamline the procurement process while ensuring fairness at both the lead agency and subcontract levels</u>.

- Procurement documents (RFI's, RFR's, etc.) should be concise (i.e. sharply limited to terms of the length of responses), in plain English, and should foster creativity by not being "regurgitative" in nature (i.e., they should not state specifically what inputs are desired, thereby forcing competitors to merely regurgitate the terms of the RFR in order to be successful). Procurement documents should be designed using a process that involves input from various stakeholders, including families.

- Procurements should be properly focused on the outcomes to be achieved and should discourage the detailed specification of the inputs and resources desired of successful bidders.

- Procurements should allow providers to present their successful past participation in the DSS service system as evidence for continued participation. DSS should consider and value past success, but not in a manner that excludes new providers from participating.

- Procurements should contain incentives for smaller, "grassroots" community organizations, minority organizations, and/or culturally specialized organizations to participate in the service system.

- Procurements of subcontractors by Lead Agencies should be conducted in a fair and open manner in which considerable information is shared with potential subcontracted participants as to the goals, objectives, and outcomes proposed to be achieved by the Lead Agency.

- Procurement of subcontractors by Lead Agencies need not be conducted in a manner that is simply a re-creation of state-required procurement procedures. Rather, DSS should work closely with Lead Agencies to develop a simpler, streamlined approach to procuring subcontracted services. Any new approach must not compromise the safety of children receiving services or the fiduciary responsibility of DSS.

- Potential subcontractors involved in the Lead Agency procurement efforts should be afforded some level of due process protections (both prior to selection and also during the term of the subcontract relationship), allowing them to raise issues of potential exclusion or procedural unfairness to the attention of a dispute resolution entity (possibly one consisting of DSS and provider representatives) in cases in which direct involvement with the Lead Agency does not bring satisfactory resolution.

<u>Use routine reporting on outcomes and quality indicators as well as a biennial review to ensure performance accountability</u>.

- The use of a very detailed taxonomy for procuring services stresses process rather than outcomes. Focusing on outcomes would allow DSS to develop a much broader set of service definitions within which providers could deliver flexible services. That said, maximizing federal revenue is an important goal for the Department and doing so requires compiling specific, detailed information about the services provided to each consumer. DSS should design streamlined methods for collecting data that can be used for multiple purposes and that balance the effort of parties in the system with the value of the data being collected.

- Greater use of case rates and family rates with specified outcomes properly rewards outcomes of services. However, developing these rates requires great deliberation and care. We would urge piloting a system of new rates and structuring frequent opportunities to review both the intended and unintended consequences.

- We believe that there should be a formal re-negotiation of the contract at least every two years. The review should evaluate whether the contract has produced the desired outcomes and if not, why not. In the interim, there should be a process for identifying and responding to emerging and critical concerns and opportunities. The review process should include input from consumers / families.

- A solid information system is a critical component of any performance accountability system. For such a system to work, it would need to be a statewide system accessible to each contractor and subcontractor. Such a system should be web-based, appropriate for a simple PC, and useable by the staff of small community agencies. This is a component of the management infrastructure that DSS should provide.

- It is important that information about performance be shared routinely not just with the lead agencies, but also with all stakeholders in the system. Individual subcontractors ought to get routine reports that show how their program performs in comparison to other similar programs in the state. Families, advocates, oversight agencies and the public will also be important audiences for performance reports.

NEXT STEPS & UNANSWERED QUESTIONS

Next Steps

As we conclude our six-month deliberations, we enter the next phase of discussing our recommendations with colleagues and partners. We hope that we will receive substantial comments, insights, and advice from focus group meetings and feedback via our Webpage. We will hold three or four small focus group meetings with a cross-section of representative individual and organizational partners in order to receive more structured feedback. All of this work will conclude by mid-May, with the final report submitted to the Commissioner by early June.

Research & Development in Current System

Workgroup members have noted throughout our deliberations that there is more innovation in the current system than perhaps we are aware of collectively. It is important to gather and share that innovation and learning in order to better inform our hypothesis about the nature of the changes needed in a new system. DSS has combined its program units into a Planning and Program Development Unit that is charged with leading these organizational learning efforts within the service system. For example, the FY03 General Appropriations Act provided DSS with budget flexibility to fund programs to divert youth from residential settings by providing care in community-based settings. The lessons learned about how to design, fund, and manage such programs are important to gather and share.

In addition to programs already in place, the Department should consider developing Research & Development pilots within the current system to test specific elements of recommendations. DSS' procurements are designed to offer more flexibility than it currently uses. DSS should also test its own internal systems for accessing and managing services. The Workgroup suggests that pilots that examine partnerships and integration across current programmatic categories are particularly important. For example, DSS has two separate referral processes to Family Based Services and to Commonworks. No change to the manner in which these services are procured are necessary in order for DSS to test changes to its own practices. It is important to keep the number of pilots small in number and to manage them in a deliberate manner.

Establish Internal DSS Operations Group / Procurement Management Team

Our recommendations raise many operational issues that must be further explored by an internal DSS group. Based on our last Workgroup meeting, the Commissioner is establishing this operations group, which will be charged with developing the operational design for the proposed model. The group will need to answer questions / conduct analyses in the following areas in order to complete its work.

- Stratify DSS caseload and Build Area Office & Regional Office Profiles

The Workgroup noted the need to understand better the different levels of service need within the DSS caseload. In conducting a data analysis, the operations group could stratify by service type currently received recognizing that the current use of a service is

sometimes defined by failing out of other services / failing into current services. It could stratify by case plan goal, by discharge reason, etc. It will also need to 'unpack' CHINS to assess how many are 'traditional' delinquent cases, how many result from a need to access behavioral health services, how many are former protective cases, etc. The data should also be used to build profiles at the Area and Regional Levels in order to identify and inform local design issues.

- Business Relationship with / among Leads

The group should assess the full array of potential contracting and financing mechanisms that could be used to establish the right business relationships between the Area Leads and the Regional Resource Centers. One of the fundamental questions is whether there is a financial relationship at all, or just performance incentives to align each one's focus and behavior.

- Determine Management Functions and Capacity

Related to the business relationship analysis, the group should assess the business capacity needed to manage the system as a whole at the Area, Regional, and Central organizational levels. We recognize that we spent limited time discussing the role of Central Office, as we focussed much more on the Area and Regional levels. We expect that DSS' Central Office will have a strong role in designing, implementing, and monitoring the required management components and infrastructure.

- Case flow examples

The feasibility of the proposed model must be tested to ensure that it can address the full range of case types that are likely to be served by Area Leads.

- Workload analysis for an Area Lead and for a Regional Resource Center

In order to complete a cost analysis and assess affordability, the Department must identify the number of families currently served in its service system as a starting point for the workload to be assigned to Area Leads. Stratifying the DSS caseload will help identify the number of cases for which Resource Center support will be needed.

- Determine Current Services to be Purchased through New System

For the sake of its analysis, the Workgroup has assumed a starting point of reprocuring residential, some contracted foster care, and family based services through this new system. However, a more precise analysis must be done. The first step will be to establish criteria to determine whether a currently purchased service (and its associated funding) should be included for purchase through the system-of-care versus purchased separately but coordinated with the new system. In addition, DSS and its sister agencies should examine the possibilities for including services purchased by DMH, DMR, DYS, etc.

Attachment A: DSS Change Initiatives
(Status as of February 2003)

➢ Enhancing the Statewide Community of Practice

Historically, the 29 Area Offices have conducted their work in widely varying ways. Some variation is appropriate customization to local circumstances, but some simply reflects idiosyncratic practice based on history, office culture, and history. The following three initiatives will raise the standard of practice in every Area Office to a level that enlists the respect and support of the entire community.

Continuous Quality Improvement

DSS executive managers have begun planning for Area, Regional and Statewide CQI systems. The Department hopes to begin to implement a CQI process across the Commonwealth this spring, understanding that the process will continue to evolve and be refined over the course of the next couple of years. The CQI system will be designed according to the following principles.

1. A good CQI system is designed for continuous learning at all levels of the Department, and does not serve as either a compliance tool or as an individual evaluation or accountability system.
2. A good CQI system addresses the entire child welfare system as a whole, including both our formal partners, such as providers and foster parents, and our informal partners in family and community.
3. A good CQI system identifies best or promising practices, and offers them for learning and appropriate replication across the Department.
4. A good CQI system provides early warning of operational problems or challenges in any office or in the larger system of care, so that the media will no longer serve as the primary monitor of Departmental operations.
5. A good CQI system serves as the primary means by which we identify needed program development or professional development to ensure the highest quality child welfare services across the Commonwealth.

Professional Development Institute

In the FY 02 supplemental budget, the Legislature directed the Department to develop a plan for establishing a Child Welfare Professional Development Institute, in collaboration with Salem State College and UMass Medical School. The Institute will establish a Child Welfare Certification program, to replace the current social work licensing. It will also expand the training offered employees on their initial employment; offer funding to support employees in obtaining their BSW or MSW at Salem State College School of Social Work; provide an extensive ongoing in-service professional development program for all staff; and provide leadership development especially for mid-level supervisors. The Department is currently engaged in design and approvals for the Institute's financial structure.

Team-based Child Welfare Practice

With a grant from the Marguerite Casey Foundation ($1M to be spent over the next three years), DSS has begun planning a process for designing and testing several team-based

models of practice. The work will involve staff from several Area Offices, with the support of researchers in organization design and clinical practice, and with feedback from parent and family organizations.

- **Creating a Community-based Continuum of Care**

The Department will develop a continuum of care to provide for the needs of our children and families in the community to the fullest extent possible. The first structural barrier to doing so was eliminated in the FY03 budget, in which the Legislature authorized spending flexibility, pooling the majority of service accounts as well as declared it the policy of the Commonwealth that DSS move children from residential settings to community-based care wherever possible. The Commonwealth has invested in an excellent residential system and has come to reflexively rely on it. The unfortunate result is the failure to develop the full depth and array of community-based alternatives that other states have put in place. A shift to a community-based continuum will not happen overnight; it will require the collaboration of all of us, our providers, the courts, the community, and many others.

- **Reforming the CHINS Process**

Over the course of last summer and fall, the Department began a dialogue on CHINS with Judge Grace, Chief Administrative Judge of the Juvenile Courts as well as the Committee for Juvenile Justice, which has been advocating CHINS reform for several years. Some of the leadership of the Legislature has also expressed an interest in reexamining the CHINS statute. The Committee for Juvenile Justice and DSS are exploring opportunities to apply for a grant to support developing a broad coalition for CHINS reform. The Department will advocate for a family-centered approach to CHINS, that focuses on interventions to address the family conditions that underlie the symptoms that prompted the CHINS process. Such an approach would require parents to remain deeply involved in the process, and would only use out-of-home placement sparingly and for short intervals, largely for diagnosis, respite and crisis intervention.

- **Deepening Our Knowledge of Substance Abuse, Family Violence, and Mental Illness**

The presence of substance abuse, family violence, and mental illness, alone or in combination, characterize the great majority of the families with whom the Department works. DSS' work to keep children safe in their families is in large part work to relieve or eliminate these conditions. The Department has approached a major national foundation to ask for support for efforts to deepen its knowledge of how to mostly effectively intervene in families that suffer one or more of these conditions. It hopes to invite leading researchers to join with experienced providers, departmental staff, and families to define what has been learned from both research and practice about family treatment of these risk factors with the goal of making the best knowledge in treatment alternatives available to staff. The Departments of Mental Health and Transitional Assistance have also expressed interest in joining this learning process, which will begin in the next few months.

Attachment B: Guiding Principles

Systems-of-care must:

- ✓ Be family-centered
- ✓ Build community capacity to serve families
- ✓ Emphasize prevention and early intervention
- ✓ Allow smooth transitions between programs
- ✓ Be effectively integrated and coordinated across systems
- ✓ Seek to evolve and change
- ✓ Provide rapid, timely access to services

Services must:

- ✓ Build on a family's strengths, in a manner respectful of the family system
- ✓ Be individualized to meet the needs of families
- ✓ Promote mutual accountability among all partners
- ✓ Be respectful of identity and affinity differences
- ✓ Be continually evaluated for outcomes

In articulating our principles for a system-of-care, we have used 'family-centered' language. However, we are mindful that this could raise the debate of the past between child protection and family preservation. We are not staking out a position on that swinging pendulum. In fact, we believe that old dichotomy is a false and irresolvable question as it has been posed and debated over the years. In child welfare work, our first and primary focus is on the child; we are only involved in a family's life because of our responsibility to children's safety and well-being (physical and emotional). However, we also know that children do best when they grow up in a healthy, nurturing, permanent family. Working with a child's family is the first / best choice for helping them thrive and succeed as young adults. When a biological family cannot care for their child(ren), then it is DSS' responsibility to find a new permanent family. We do not engage in a "child or family" debate but in a "families for children" commitment.

System-of-Care Principles and Indictors

The system-of-care must be family-centered. Families are defined in the broadest sense to include all family members (not just parents) and kin. Children without biologically families and older youth must be supported in finding and sustaining families and/or networks of support.

A. Families should be involved as equal partners in decision-making about their own service plans and treatment options. This early, on-going involvement establishes relationships families know about and can access after DSS involvement ends.

B. Youth should be involved in decision-making about their own service plans. This should be standard practice for youth once at the age of 14; it may occur sooner depending on the youth's ability to participate.

C. Each family has its own natural system-of-care that must be the first source of solutions to strengthen the family and that should be enhanced through the family's involvement with DSS.

D. Parent partners / parent peers should be available to support and guide families as they enter DSS, enter the purchased services / system-of-care, and throughout their involvement with the system. Parent partners could be helpful in mediating family-provider relationships experiencing problems, particular in the early stages of changing practice to include a central role for families.

E. There are no valid excuses for not involving families. Providers must work with families to resolve barriers to involvement, including transportation and other accessibility issues.

F. Family and youth representatives should participate as leaders at a system level in such functions as policy development and review; planning and developing services; and training staff and volunteers.

G. RFRs should include "family-friendly" criteria and award those agencies that meet the criteria with a Family-Friendly Seal of Approval. Agencies not receiving such approval, but still awarded a contract, must enter into an action plan in order to meet "family-friendly" criteria.

H. Language should be both free of jargon / bureaucrat-ese and in the family's primary language.

I. Individual services and the system-of-care must be organized for the comfort of families not the comfort of DSS, individual providers, or the provider community.

The system-of-care must build community capacity to serve families and promote sustained connections to kin and community support networks.

A. Providers should be required to bring their own resources to the table for families they serve and to open up other community supports for them. Providers should

help families establish relationships with community services that can extend beyond their involvement with DSS.

B. Providers have an affirmative expectation to remain accessible to families they have served and to be a stakeholder in each family's success. Families should have a "preferred relationship" in the future (post-discharge) with providers.

C. DSS has a parallel obligation to be a stakeholder in each family's success. (*Can families come back for support / 'single service'?)*

D. Youth should arrive at emancipation with a network of support in order to transition to adulthood successfully. DSS and its providers have an obligation to be a stakeholder in the success and well-being of youth who have aged out of the system and to support them as they move into adulthood. This includes remaining available for guidance and support after the case closes. (*For how long? Till age 19? 20?*)

E. Some communities lack a rich array of resources to effectively support families and will need to develop a variety of new services. DSS should partner with sister state agencies to maximize the use of all service dollars in each community. DSS should also actively support fundraising for community agencies as a reflection of its commitment to building community capacity.

The system-of-care must emphasize prevention and early intervention.

A. The system-of-care must target services on prevention of: continued DSS involvement, cyclical involvement, and placing children in out-of-home care.

B. The system of care should allocate resources to early intervention, not just to placement and 'deep end' services.

C. The system should not allow or accept "promotion by failure" or "failing up".

D. The system should offer support services to families who have come to the attention of DSS but for whom there is no substantiated cause to open a case.

The system-of-care must ensure that a smooth and seamless transition between programs accompanies families as they develop.

A. Transitions present the greatest challenges in supporting and strengthening families (e.g. placement change, change in services, change in provider). Routine mechanisms for transmitting knowledge bridge these critical transitions.

B. DSS' assessment should be sufficient to begin service access / provision. While providers might be asked to conduct a specialized assessment (e.g., firesetter, sexual offender), they should not re-do DSS' assessment.

C. In anticipation of any change in provider involvement, the current staff should be required to work with new staff. There should be, at minimum, a face-to-face sit down meeting at which current staff brief new staff on services, progress, etc.

D. There should be one case record that is accessible to all participants in a timely manner. Information should be complete, so as to avoid new staff re-doing and filling in gaps.

E. Continuity is not just an issue when a youth leaves residential placement to return to their family. Continuity is important for services to intact families as well as with adoptive families. Challenges to seamless transitions (e.g. distance) must be addressed by service providers.

F. Relationships are not linear. Involvement in the system-of-care is a matter of building a network for a family, with the family. All parties who work with the family should remain stakeholders in its success.

G. Providers' discharge planning responsibilities should include responsibility for follow-up. For example, MBHP requires three telephone calls post-discharge from an ART.

H. Placement providers should take back youth who leave the program as the result of a crisis or by running *–always? At least once? If the youth is not going back, when must that decision be made in order for youth to not be in limbo?*

I. Some placement transitions may be eased by allowing a child to visit a new placement prior to beginning full-time. Others may be eased by allowing a child to return to a more structured setting on a limited basis. The administrative / payment systems should allow for some reasonable time-limited overlap in payment for two placements.

J. When a family / child experience a problem, all previous providers have an obligation to come to table to share their experience / knowledge with the current provider in order to develop appropriate solutions. This obligation is not time-limited (*or is it to one year?)*

K. DSS should share information regarding a child's treatment and experience while in care with any family member caring for child after the case closes (e.g., a relative guardian).

Systems-of-care must be effectively integrated and coordinated across systems and built on real capacity for interagency collaboration at the community level.

A. A "single point of entry" into the service system is valuable only if it provides entry into an integrated system delivering quality services, not an initial stop before encountering fragmented services.

B. Residential and community resources should be blended and permeable via structural linkages, especially across providers located within an Area Office's catchment boundaries.

C. Providers have a responsibility to the specific Area in which they are located – to be a good neighbor, to be a good partner. For example, a residential provider could offer empty weekend beds for respite for foster homes in that area.

D. There should be regular meetings of the Area Office CQI Team, including providers and families.

E. To be truly effective, the system-of-care must incorporate services funded by DSS' sister human service agencies. This could be accomplished through co-location, coordinated planning, and/or coordinated or joint procurement of services. Effective partnering is predicated on agreement regarding the outcomes for families sought across all systems.

The system-of-care must seek to change in response to evolving needs, opportunities, participants, knowledge, skills, and resource development.

A. DSS must have an effective continuous learning / continuous quality improvement system in place that includes review of its purchased services.

B. There should be regular forums of practice development with providers across service 'categories'.

C. RFRs and resulting contracts must contain provisions to allow for changes in scope as the system-of-care evolves (without re-bidding the service). Contract changes must be negotiated and supported by all parties.

The system-of-care, as a whole, must have the capacity to provide rapid, timely access to services.

A. Families' need to access services through DSS is not limited to M-F, 9-5. The system-of-care must be able to provide services 24-7-365, particularly crisis stabilization services.

B. A qualified staff person should be accessible to families for consultation 24-7-365.

C. Services should be available immediately upon a family's initial contact with the Department (within a maximum of 1 to 5 days).

D. Better coordination of after-hours response across agencies.

Service Principles and Indictors

I. Services must build on a family's strengths, in a manner respectful of each family's own unique system-of-care.

A. Every family brings assets, abilities, resources, knowledge, resiliencies, and their own natural system-of-care that must form the foundation upon which solutions and service plans are built.

B. Services must be delivered in a manner that meets the family's choices about the nature, timing, and location of services.

C. Professional staff should be flexible, not directive, in working with families. Service delivery should not upend the healthy functioning of family life.

D. Families should be supported in involving kin and their networks of support as they develop solutions as well as in re-connecting with kin and establishing supports.

II. Services must be individualized to meet the needs of families.

A. Services should be purchased in a manner that allows bundling and unbundling of services in order to meet each family's needs.

B. Services must work holistically, addressing each child's social, emotional, medical, psychological, and educational needs.

III. Services must promote mutual accountability among all partners (e.g. DSS, contracted providers, and families).

A. DSS' RFRs, Service Contracts, and subcontract agreements should clearly state requirements for providers. There might be graduated requirements, with the greatest falling on the largest providers able to bear / spread costs more economically.

B. Families lose trust in the system-of-care and in DSS when they encounter poor services. Therefore, DSS must set standards and hold providers accountable to meeting them.

C. DSS is accountable for providing timely and complete information to service providers.

D. There should be financial accountability (administered through the rate structure and/or payment system) for providers to adhere to program standards set forth in their contracts.

E. Families receiving (*voluntary and/or CHINS?*) services retain financial responsibility for their child's care. Parents should pay a sliding-scale fee for *out-of-home services (or any service?)*.

F. In a system-of-care that integrates services funded by DSS' sister human service agencies, definitions, standards, and processes for accountability must be integrated across all partner agencies.

IV. Services must be respectful of identify and affinity differences.

A. Individual families, family members, and youth define their own identify and affinity, which may be based on class, race, ethnicity, and/or sexual orientation.

B. Individual differences of identify and affinity must be respected by all service provider staff, DSS staff, parent partners, and any other caregiver involved with the family.

V. Services must be evaluated for outcomes continually and modified to improve outcomes for families.

A. Outcomes and performance measures should be clearly articulated in all service contracts.

B. Rate structures should include financial incentives for exceeding performance standards and/or achieving outcomes.

C. The evaluation of purchased services and their outcomes should be conducted as part of the Department's continuous quality improvement program.

D. Data collection, analysis, and interpretation should be conducted by a team that includes, at least, service providers and families.

Attachment C: Workgroup Analysis of Lead Agency Models

Informed by the *Principles*, the system-of-care subcommittee formed a preliminary assessment of the structural components and management functions required in a successful system-of-care. The subcommittee then considered possible approaches to purchasing services to form an integrated system-of-care. [2] We started by testing the hypothesis that DSS Area Offices could and should purchase services directly (essentially functioning as its own lead agency, in conjunction with its Regional Office) and generated a list of reasons for and challenges to this approach. We then examined using area-based lead agencies, followed by examining regional-based lead agencies. We concluded that the benefits of using lead agencies outweigh the challenges and that the challenges can be addressed through good design and management. In using lead agencies as we envision them, the Department can create public-private partnerships that have the potential to build and support a wide community commitment to caring for children.

Three approaches were considered and rejected, before a model emerged as the preliminary recommendation / working hypothesis. The Workgroup identified the affirmative reasons for and challenges to each model, as summarized in the following table. The three rejected were:

- DSS Area Offices act as their own lead agencies, purchasing all services directly from providers

  In this model, the DSS Area Office essentially functions as its own lead agency. The Area Office holds contracts with each service provider. DSS retains all management responsibilities, some of which might be handled by the Regional Office (such as cross-Area network issues, coordinating a CQI process, contract monitoring). The system-of-care subcommittee felt there were sufficient challenges to the "DSS as its own lead" approach to consider the use of contracted lead agencies.

- DSS purchases 29 Area-based lead agencies (one per Area Office), which then subcontract for network services

  Each Area Office has its own Area-based Lead Agency for all purchased services / dollars to be included in system-of-care. [Note this does not imply there would be 29 different providers serving as Leads.] The Lead would also access services and natural supports available in the community and from other state child-serving agencies. The Lead Agency would provide a range of management functions. The one exception would be managing cross-Area issues, which would be addressed by the Regional Office. The Lead agency could contract with other state purchasers (jointly with DSS at the time of its procurement, or separately but in a manner that

[2] Our assumption is that the current service groupings to be integrated through this model are family-based services, therapeutic foster care, and residential (Commonworks and Autho). There are other services purchased by DSS that might be included based on further analysis.

builds on/coordinates efforts) and become an integrator of services across state systems.

- DSS purchases 6 Regionally-based lead agencies (one per Regional Office), which then subcontract for network services

  Each Regional Office has a Regional-based Lead Agency for all purchased services / dollars to be include in their respective Area Offices' systems-of-care. The responsibilities are the same as those of the Area-based Leads, described above. Regional Leads could choose to subcontract to local providers to handle Lead functions in a particular Area if the Lead felt it was not close enough to the community.

Model Emerging as our Working Hypothesis

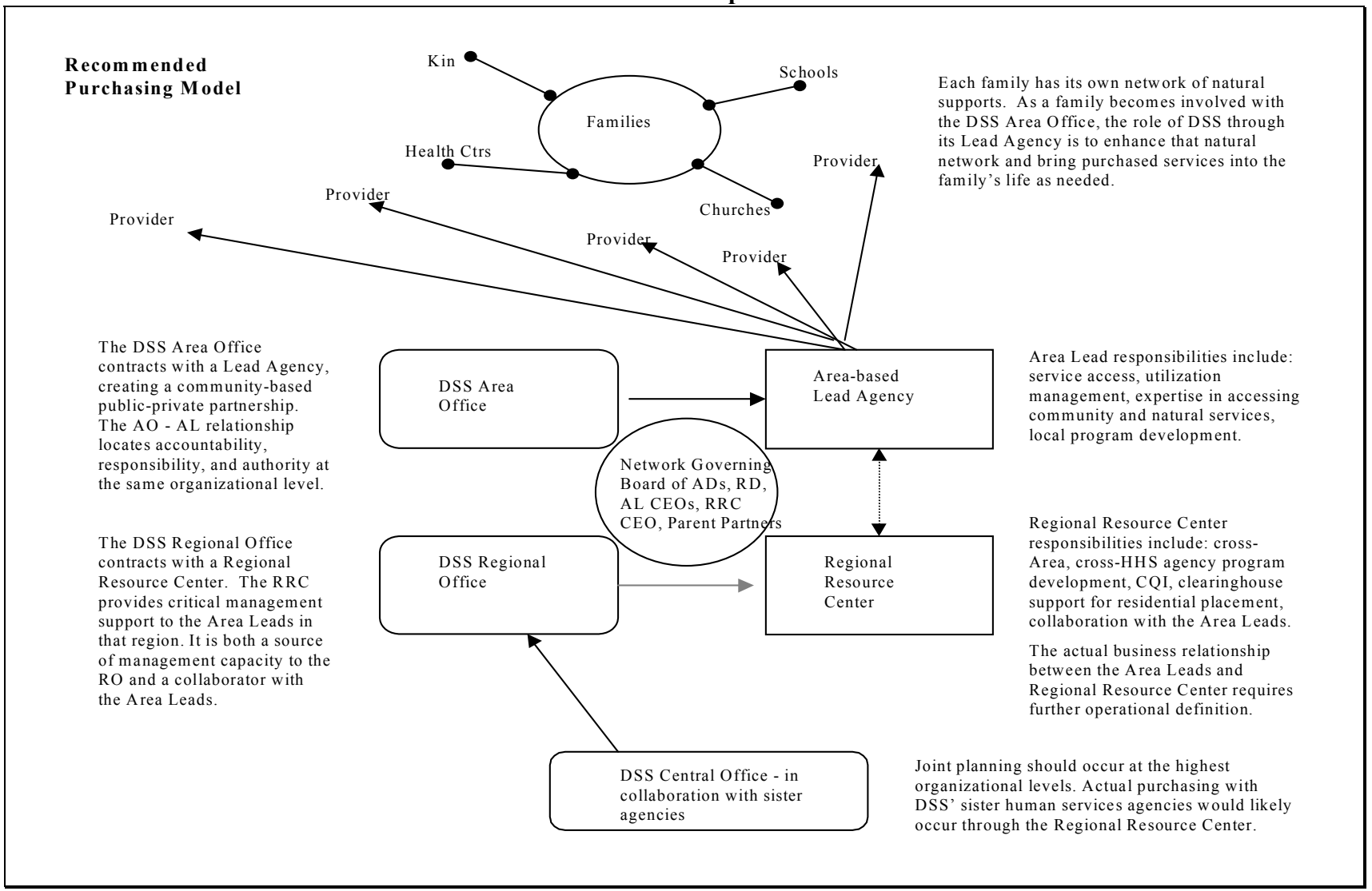
Based on its discussions of the three models above, the system-of-care subcommittee then developed a 'hybrid' model that seeks to take advantage of the benefits of area-based leads and regional based leads. (See Attachment C) This model envisions Area-based lead agencies to serve as partners to the Area Offices. They would bring local knowledge and resources to their task of building local community-based networks, helping to 'nest' child welfare services in local community systems. Area Lead staff would manage service access, treatment planning, and utilization review. The Regional Resource Center would provide management support (including functions such as cross-Area program development/redesign, subcontract/rate negotiation, purchasing from statewide systems) to the Area Leads. The Resource Center could also provide intensive service/care management for high-risk children and their families, likely to be accessing services across systems as well as 'low frequency' special needs / special populations.

Attachment C: Reasons for and Challenges to Lead Agency models

Reasons	DSS Area Office (AO) as its own Lead	Area-based Lead Agency	Regionally-based Lead Agency
Direct knowledge of local community's available services and natural supports.	AO connects to the community through its mission to protect children and strengthen families.	A provider acting as Lead may be more connected than AO to full array of community services and natural supports. Lead would be required to build knowledge of local community, map services /supports, extending the AO's reach.	A provider focusing on region-wide issues risks being more distant from local communities.
Ability to understand current service needs, anticipate future needs, and respond to both.	Responding to daily events/crises often overwhelms AO's ability to focus on future needs. Practice generally overwhelms learning.	A Lead could focus exclusively on services, would be better able to focus on long-term development of its network.	Same as Area-based Lead.
Ability to form relationship with families.	DSS' mission requires it to work closely with families. Case practice increasingly uses family group conferencing and strengths-based planning.	A provider responsible for developing a network /full array of services would bring community into partnership with families. This would support the development of relationships that could be sustained post DSS involvement.	Same as Area-based Lead.
Ability to form relationship with providers.	Emphasizes providers' relationship with DSS AO. Providers would have direct relationship formalized through a contract. Would statewide providers have to establish and maintain relationships with 29 AOs?		

Facilitates service integration across other state child-serving agencies.	29 AOs reaching out to other HHS agencies would be inconsistent and fragmented.	29 Area Leads reaching out to other HHS agencies would be inconsistent and fragmented.	6 Regional Leads would be better positioned to work with other HHS agencies, which are also organized as regional systems.
Facilitates service flexibility, continuity across transitions, responsiveness, etc.		Flexibility in funding and subcontracting allows Lead to develop unique programs more easily, including client-specific transitional supports.	Same as Area-based Lead.
Innovation can be supported and incentivized through a range of financing tools.	Individual maximum obligation contracts are less flexible – unless with one provider for full array, which would make participation of small providers less likely.	Pooling dollars under a lead agency contract allows for more flexibility. DSS can establish financial incentives for identified strategic outcomes. Flexibility of private providers becomes available to DSS.	Same as Area-based Lead. In addition, regional level lead would have greater number of cases across which to spread financial risk.
Provides effective management infrastructure in most efficient manner.	Little infrastructure exists in AOs, nor likely could be built. Service system would be weakened by inability of AO to manage appropriately.	Would be inefficient to build management infrastructure at level of 29 Leads.	Most efficient allocation of management infrastructure.
Assigns effort to manage services where expertise exists (or reasonably can be built).	'Span of attention' too unwieldy for an AO. AO would be hard pressed to become expert in all required areas and do all functions well.	Gives Area Director a management resource / partner able to focus on the important area of purchased services. Allows AD to focus on internal systems.	
Ensures consistent standards and business practices with providers.	Risk of not having universal program and quality standards consistently applied – would be a burden to providers.	Risk of not having universal program and quality standards consistently applied – would be a burden to providers.	Better chance of enforcing / ensuring consistency.

Attachment D: Proposed Model



Attachment E:
A Vision for a Community-based System of Care

The following is the vision offered by one of the member's of the Workgroup. While it is not the product of the Workgroup, it is the result of participation in the Workgroup's extensive deliberations. Telling a story about what the system looks like three years from now is a powerful way to present a grounded vision for change. We encourage readers to share with us their vision of what the system will look like in three years.

Three years from now, I hope that I can walk into the local office of the Department of Children and Family Services' DSS office in Springfield and have a very different experience than I might have today. First of all, the local DMH and DSS offices have been co-located and share a receptionist. She is both welcoming and extremely well-trained in all of services available to children and families in the city. She will either make a quick appointment for the family to see the intake worker or help the family call another more appropriate service for assistance. The DSS/DMH offices are located very near DTA and the Child Guidance Clinic that makes referral to those agencies very easy.

Over the past three years, DSS and DMH have done joint procurement of several services while remaining separate agencies with separate missions. DMA is a frequent partner in these procurements. They share intake and, when appropriate, assessment services. The intake worker determines the appropriate agency for lead responsibility and ensures that the team will have sufficient diagnostic information to make a good decision about the services needed. A referral is made to either DSS or DMH as needed.

Walking through the office I see the major component of the new system at work. In a small conference room the team is meeting. Family members, the DSS Social Worker, a service manager from the DSS Lead Agency, and a minister who has been involved with the family for many years are meeting to review the initial assessment and make a determination of the first services needed. The Lead Agency staff person seems to be the convener of this meeting and has been well-trained in the skills needed to ensure that everyone gets to participate, that conflicts are dealt with creatively, and that the group is strongly encouraged to come to consensus. This group does arrive at consensus but later that day I discover that there are two levels of appeal, one to the Area Director and the other to the Regional Director. These appeal systems are rarely used, but they have been important in resolving some disagreements.

Later that day I talk to the Director of the Lead Agency who describes the system of care. In addition to the Intake Process, I discover that the Hotline and Investigation process is relatively unchanged from 2003. The DSS social worker also has many of the same responsibilities, but now works much more in the team model. The range of more in-depth assessment services such as Bridge Homes also look similar to those available in 2003. They are used when the team needs a more thorough understanding of the child and the family.

However, the community-based system of care has many different services and is managed differently. First of all DSS, DMH and DMA have jointly funded a 24/7 emergency services, respite and stabilization service for children which ensures that a crisis assessment can be made as needed and that a flexible array of short-term stabilization services including in-home supports, foster care, or 24 hour respite can help a family manage a crisis situation with the minimum level of care necessary. This system has worked to divert children from a hasty out-of-home placement and also serves as a back-up to many other services as well.

Secondly, there is a Local Lead Agency that has developed and managed a system that includes the services most used on a regular basis. This Lead provides a range of services to DSS families and to DMH families where appropriate. There is a strong focus on in-home and community services including many provided by local agencies such as community centers, community mental health centers, Big Brothers/Big Sisters, AA, local churches, etc. DSS also includes some other important services such as parent aids, home visitors, and intensive case management. The array of services in Springfield is particularly designed to serve our many cultural groups including Latinos, African Americans, and Vietnamese.

The Area Lead also manages a range of out-of-home placements including a variety of foster care placements and some short-term residential services. It accesses less frequently used services that have been developed and managed by the Regional Resource Center. These services include such things as services for medically fragile children, for sex offenders and fire setters, and for children in need of an intensely supervised behavioral residential setting.

As I talk to the Director of the Area Lead Agency, I find that the Lead is responsible for developing a sufficient array of these services and having them available via subcontracts or via community referral. Subcontractors must be properly licensed and participate in the quality management system in order to participate. They hold a range of different types of contracts from case/family rates to maximum obligations to fee for services depending on the type of service and the area need. A staff from the Lead Agency convenes the treatment team and participates as the member who is particularly aware of the array of options available in Springfield. However, the heart of the area system is still the entire team that takes the time to develop agreement on the best course of action for the child and family. Even if the child is placed in a specialized out-of-area service, this team is involved both in monitoring that care and in any decisions to make major changes in the services offered.

A final part of the Area System is the local Advisory Board. This group has attracted excellent representatives from key stakeholders of this system. Families are very active as are local officials, and representatives from local schools, courts, and community groups. This group has been involved in the development of the new system of care and regularly reviews data on performance, advising both the Area Director and the Area Lead about concerns.

As I delve further into this new system, I find that many of the support systems needed for this local system are available from either the Regional Office or the Regional Resource Center. The Regional Office handles all business affairs and is responsible for overseeing (but not necessarily deciding) any major procurement processes. It also has taken the lead in organizing much further collaboration among all the child-serving agencies in the Region.

Of major note is that there have been a great deal of change in the business practices of the Department. Procurement practices have been streamlined; pricing policies protect against monopsony and are far more transparent; prices are adjusted routinely for cost-of-living and new mandates; and performance is reviewed via clear reporting rather than the awkward Taxonomy.

Most important, given the memories of the difficult years between 2002-4 is that all EOHHS agencies are in the second year of a four-year plan to raise direct care salaries of community workers up to a level sufficient to attract and retain a qualified work force. By the end of the four years, salaries will be 25% higher on average in inflation-adjusted dollars. The on-going adjustment of rates for multi-year contracts will keep those salaries competitive.

The Regional Resource Center has developed and managed a series of specialized services and offers a triage service to all the Areas to ensure that scarce services are distributed according to the most pressing needs. Many of these services, particularly residential treatment with a strong behavioral focus, are available both to DMH and DSS families and have integrated third-party billable services into care in a creative fashion. The Regional Resource Center also collects data on performance and operates the Quality Monitoring function for all the Area systems. It sponsors staff development opportunities and is also involved in developing and testing new models of care.

In summary, I am pleased that the vision we constructed back in that snowy winter of 2003 is actually working, and that far more children are remaining with their families or moving quickly to adoptive or kinship care. Most importantly – all the children are safe. The system is there making sure that the child is safe and cared for 24/7 for as long as is needed. It's a system that is working.

Attachment F: Proposed Criteria for Evaluating Recommendations

In addition to assessing the extent to which a recommendation supports and promotes our *Principles*, each recommendation should be tested for Variability, Usability, and Feasibility.

Variability

There is great variability in the provider community, the communities in which the Department works, the families involved with the Department, and in the types of services the Department purchases. How does the recommendation support:

- Small community agencies, minority business enterprises, large multi-service agencies, large single service agencies, etc.
- Urban, suburban, and rural communities
- Extended families, young families, teens, etc.
- Services delivered only to families involved with DSS (closed referral) and services delivered to non-DSS involved families (open referral)

Usability

The goal of this procurement review is to provide recommendations that can be utilized by the Department in future procurements.

- Is the recommendation clear and concrete enough to guide the procurement process post-review?
- Is the recommendation actionable?
- Does the recommendation support and advance the Department's child welfare case practice philosophy?

Feasibility

The recommendations should speak to both the world as it is as well as the world as the Workgroup envisions.

- Is the recommendation realistic given the current revenue shortfalls faced by the state as well as the resulting staff capacity at the Department?
- If what is feasible in the current context is less than desirable, does the recommendation identify steps that could be taken in order to advance the purchase-of-service system towards the desired goal?

Attachment G: Outcome Type and Definition

There are three types of outcomes: client, process, and system. It is important to align the focus of providers and the standards for which they are accountable with those of the Department. Specifically Area Offices and Area Leads should be held accountable for the same outcomes as should Regional Offices and Regional Resource Centers. The standards /outcomes for network providers should be consistent with those for the Leads. Consistent standards and measures should be used to bind the efforts of all parties.

Client outcomes are those that measure the safety, well-being, and permanency of children at both the individual case level and are aggregated up to the area, regional, and statewide levels. The Workgroup agreed that the measures established in the Federal Child & Family Services Review report on DSS as well as DSS' Program Improvement Plan should be the focus of the purchased system-of-care (at least until such time as they are achieved; additional measures could then be added).

System outcomes are those that measure the functioning of the system as a whole. They are not simply aggregated client outcomes. In general, there are three areas of system outcomes: quality, access, and cost. Access can be defined both in terms of time (to receive a service) and distance (between one's community and the location of service delivery). Standards specific to emergency response could be set. There are likely numerous measures of quality – which the Workgroup did not identify specifically. In assessing cost, it is important to assess cost effectiveness and cost efficiency. Services should be delivered in the most efficient manner; there should be neither underutilization nor overutilization.

Process outcomes are those that measure the degree to which required processes are followed. They can /should be tracked at a provider level, network level (Lead Agency level), and statewide. For example, a key principle is involving families in case decision-making. The number of families participating in treatment team meetings could be tracked against an expected benchmark. The Workgroup did not identify / recommend specific process level outcomes but pointed to the *Principles & Indicators* as the source for developing the right outcomes.

Attachment H: The Power of Monopsony

Underlying our discussions about how to use a wide range of procurement tools to promote best value in purchased services is a set of assumptions about the market and the state's role it in. We view the market for purchased human services as a monopsony, i.e., a buyer's monopoly, a market situation in which the product or service of several sellers is sought by only one buyer. The fact that there are several purchasing agencies is a function of the fragmented organizational design described above. In fact, state government is a single buyer. All purchasing agencies are governed by one set of procurement regulations, one budget-setting process, and one accounting system. It is a highly centralized system with dispersed control for some decisions. Suppliers (providers) have two choices: do business with the sole buyer (the state), or don't do business at all (go out of business).

However, this is not a monopsony operating in an environment where providers seek to maximize profits in a traditional market model. The suppliers here are mission-driven and usually not-for-profit agencies. They will rarely choose to not do business with the state if by doing business they can benefit their clients, even if this is done in a manner where they risk financial harm. In addition, the state is not just the only buyer; it is also the primary regulator of the market. As such, it exercises a great deal of control over the manner in which providers can design, finance, and deliver services. There is a danger posed by this buyer's monopoly combined with suppliers who will always seek to do business in accordance with their missions. A buyer in this position could easily devour its own market; suppliers risk letting themselves be devoured. The result can be harm to children, families, and communities. Therefore, the state has an incentive to prevent its purchasing agencies from taking actions that risk this harm. At a fundamental level, this requires the creation of and ongoing commitment to clearly defined business practices and procedures that are managed in an open, transparent manner. Many of the Workgroup's recommendations reflect such an approach.

The proper response to the market's impact on pricing is the one that has been the most challenging with which to grapple. The business practice subcommittee discussed the extent to which the state should set parameters that offer basic protections within which providers are asked to / able to compete. One approach is for DSS to set parameters by identifying a floor on entry level salaries and determining market rates for other key program components. These parameters could be used as guidelines in rate negotiation, i.e., providers could vary in any direction so long as they could demonstrate that their decision would not undermine best value. Another approach is to simply let the market speak through providers' bids in response to a competitive procurement. However, there is concern that this later approach would result in contract awards based on 'low ball' bids made at the expense of staff, quality, and outcomes. We do believe that there is value to be gained in introducing features of a competitive market to the procurement of human services. Providers can and should compete for contracts based on their ability to deliver quality services and achieve desired outcomes at a price that delivers best value. Financial incentives properly aligned with the right outcomes can have a positive effect on performance.

Attachment I: Defining Key Terms

As a prelude to forming and presenting our recommendations, we wanted to define for ourselves a couple of key concepts: flexibility and integration. We also realize that "blended" or "braided" funding is likely to be essential to our recommendations and present some definitions of these concepts. These terms come up repeatedly in our discussions and we want to (1) create working definitions for each, (2) understand how they fit together, and (3) test the proposed model against them.

Flexibility

The term 'flexible' is used to describe a number of aspects of service design and procurement. Dollars, services, provider selection, rates, and licensing/regulations are all identified as needing to be 'flexible.' It is important to articulate what this means in these domains and the reasons it is seen as desirable.

- Funding should facilitate the purchase of any service or item that is deemed necessary to meet the identified outcomes for a child / family. In some cases, a child / family needs services that cannot be readily accessed from contracted providers. When accessing the needed services is clearly tied to achieving case plan goals, "flexible" funds should be available. The flexible funds that the Department currently includes in its Family Based Lead Agency contracts are a good example. These dollars are not authorized via FamilyNet service referrals. However, services and items purchased are reported with the monthly payment / PV and tracked in a separate database in order to ensure a proper level of accountability.

- Contracted services should readily adapt to the changing needs of families, guided by the desired outcomes. This flexibility should exist at both the network / system level and the provider level. Services should be adaptable in a number of ways, including allowing changes in frequency, intensity, duration, location, type, and number of staff involved.

- The selection of a particular provider(s) to work with a family should ensure that families' needs are met in the best possible way by the best possible available provider. Choosing the right provider means not locking in all dollars with a limited number of providers through the use of all maximum obligation contracts.

- Rates should support meeting the individual child's / family's needs. One way to do this is to establish tiered case rates as contained in the system-of-care subcommittee's proposal. To the extent that differential rates are utilized, they should be based on a standardized assessment tool.

- Licensing and other regulations must allow for service flexibility to meet individual child / family needs (while remaining consistent enough to ensure quality care and safety protections). Currently, regulations can be over-prescriptive and lead to "one size-fits-all" programs that both inhibit service innovation and drive up costs unnecessarily.

Integration

The term 'integrated' also is used to describe a number of aspects of service design and procurement. Services, service planning, service procurement, working with families, and management functions such as monitoring and evaluation are all identified as needing to be integrated. We believe that integration is different from coordination. Coordination suggests communication among separate providers / programs – who are not necessarily doing the same thing or working in an integrated fashion. Of course, coordination among entities that are working in the same direction is valuable and an important component of the system-of-care. However, we believe that 'integrate' packs more punch. It is important to articulate what it means to be integrated in these domains and the reasons it is important.

- Services must ensure the most efficient use of resources in achieving outcomes for children / families. Service integration must occur at both the child / family and system levels. Services should be integrated across state agency systems as well as across non-purchased community services and DSS purchased services. The integration of human service agency experts on teams can facilitate this service integration at both levels. Integrated teams help to identify and address issues of service access and capacity across service disciplines.

- The work of providers with families must create a system, not a hodge podge, of care. Providers must integrate their efforts within both the purchased services and natural supports that form a family's own system-of-care. Integration of effort requires clear communication, joint meetings, and shared goals. The Workgroup believes that a Single Service Plan should be the key integrating mechanism. A single service plan requires shared ownership of treatment decisions and outcomes by all parties. Where there is an IEP, the two plans need to complement each other.

- The Workgroup recognizes that the highest level of integration will occur when a single organization is charged with assisting the family to implement the service plan. Contracting methods should support such integration through such techniques as developing broader definitions of service, through use of case/family rates, and through appropriate rewards at the subcontractor as well as the lead agency levels. We are also mindful that such approaches cannot be exclusive of small community-based agencies that don't have the capacity to provide such integration but nevertheless offer a great deal of value to children / families.

- Service procurement should be integrated to the maximum extent across state agencies. This could mean purchasing services jointly, with more than one purchasing agency entering into a single contract with a provider. However, it need not be technically complex: it can also mean purchasing in a coordinated manner that ensures there is no gap in services nor any duplication across services. For example, child care need not be purchased jointly by OCCS and DSS, but it should be purchased in a manner that allows the scope of child care services to 'meet up with' the scope of services purchased by DSS. For example, a family might need child care

only two days per week, not the five days per week per child as defined by most child care models.

- Licensing and other regulations should be integrated in their design, scope, and application. As with service scopes, there should be no gap, duplication, or contradiction in the regulations and licensing standards. For example, a residential program with a child care component that supports young mothers in placement must be licensed separately for its residential and its child care programs.

- Management functions must be integrated within DSS as well as across purchasing agencies in order to reduce the resource burden and fragmentation facing both the state and its contracted providers. Monitoring and evaluation by human service purchasing agencies has long been identified as costly and ineffective due to the lack of integration of purpose and effort by the state agencies. The supporting role of reporting and data collection is similarly fragmented.

Blended and Braided Funding

The terms "blended" and "braided" are used, often interchangeably, to describe utilization of multiple funding sources to support a single service or client. The Workgroup recognizes that using multiple funding sources can be both advantageous and necessary. The first step to recommending an approach is more precisely defining what we mean by these terms. [This is not to say that we have a monopoly on the 'right' definitions, simply that we want to be clear and precise in our recommendations.]

"Braided" funding is the term that seems to be in vogue most recently. It describes the pooling of dollars on behalf of a client (or group of clients) in a manner that the dollars don't lose their unique character as defined by the originating funding source (state or federal). An example of this is the Enhanced Residential Care (ERC) program, operated through the Commonworks Program. The ERC program is designed to integrate clinical expertise with services provided in a residential milieu setting for particular youth. ERC is funded by both DSS dollars and Medicaid/MBHP dollars through case rates. The providers participating in the program submit one bill, making the two funding sources appear seamless operationally. However, they do need to report the two sources of funds separately in their financial statements.

Blended funding has long been used to refer (incorrectly) to what we described above as braided funding. The term 'blended' suggests that when dollars from multiple sources are put together they all become the same, i.e., they lose their unique character (and constraints) and one dollar can be used like any other in the pot. This is clearly not true in the braided funding definition. An accurate scenario for blending is when the purchasing agency uses state appropriated dollars to pay providers, and then claims FFP reimbursement to the General Fund. The Rehab Option is an example of this. DSS claims Medicaid reimbursement under the Rehab Option for certain services that it pays for out of its appropriation account. The state-federal claiming transactions are invisible to the providers. The providers do need to be certified periodically as delivering reimbursable services.

When funds are braided, the expertise and support of the participating agencies becomes braided as well. Braiding funds takes some work in developing a shared vision and agreement across disciplines about program design and operation. However, it can result in a shared commitment and support for the program. It is inevitable that agencies will seek to protect the integrity of their funds and the programs purchased.